

Use this form to authorize Holding Arms L.L.C. to release health information, or to authorize another organization or person to release information to Holding Arms. Under Minnesota law (Minn. Stat. § 144.293), your health records cannot be released without your signed and dated consent.

CLIENT INFORMATION

Client Name		Client ID # (optional)	
Phone #		Date of Birth	
Address		Legal Guardian / Authorized Rep.	
City/State/Zip		LG Phone #	

THIS RELEASE AUTHORIZES THE EXCHANGE OF MY HEALTH INFORMATION

☐ From ☐ To		☐ From ☐ To	
Organization/Person	Holding Arms L.L.C.	Organization/Person	
Address	9001 E Bloomington Fwy, Ste 129B	Address	
City/State/Zip	Bloomington, MN 55420	City/State/Zip	
Email	akahin@gmail.com	Email	

HOW AND WHAT TO RELEASE

☐ I authorize release by email*	Dates of records: Start: _____ End: _____
☐ I authorize release in writing	
☐ I authorize release verbally	

* By checking this box, I acknowledge that although Holding Arms uses a HIPAA-secure email system, email may not be a secure method of communication, and the sender and receiver cannot guarantee the privacy of information sent by email.

For the purpose of	Records to release
☐ Treatment planning & care coordination ☐ Payment / insurance ☐ Legal ☐ Client request ☐ Other: _____	☐ Diagnostic assessments ☐ Functional assessments ☐ Individual treatment plans ☐ Dates and costs of service ☐ Other: _____

Limits I place on this release (optional)	
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Use this space to note anything you do **not** want released. Holding Arms will honor any limits you write here.



Expiration

This authorization is valid for **one year from the date it is signed**, unless you write a different date or event below (Minn. Stat. § 144.293, subd. 4). You may revoke it sooner at any time.

☐ **Alternative end date or event:**

By Signing This Release, I Acknowledge That

- I have the right to revoke this authorization at any time by sending written notice to Holding Arms L.L.C. A revocation is not effective for actions already taken in reliance on the authorization.
- I may refuse to sign this release. Holding Arms will not refuse treatment because I decline to sign it, unless the release is needed for treatment, payment, or another purpose the law allows to be required.
- Holding Arms cannot prevent re-disclosure of records released as a result of this request, and the records may no longer be protected by privacy rules once released to a third party.
- If I choose email as a means of communication, Holding Arms has explained that email may not be a secure form of communication, and there is no guarantee that information sent by email is secure.
- I have received a copy of this form, if I asked for one.
- I have read this form and/or have had it read to me and explained in a language that I can understand.

Client / Legal Guardian		Date	
Signature		Relationship (if not client)	

☐ Client/LG provided verbal authorization to the witness

☐ Client/LG refused or was unable to sign. Explain:

Witness		Date	
Signature		Title	